

PostScript

LETTERS

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Vaginitis emphysematosa

Vaginitis emphysematosa is usually a self limited cystic disorder of the vagina. The paucity of reports on this rare entity and the fact that it can first present to the sexually transmitted diseases (STD) clinic where, for want of a better diagnosis, it may be passed off as condyloma acuminatum, prompted us to document the condition in a young woman.

Case report

A 29 year old gravida 8, para 8 woman presented with an asymptomatic growth in the vaginal introitus of 2 years' duration. It had started spontaneously, gradually attained the size of a small lemon, and had remained as such for months. On examination she was of average build and nutrition without any associated disorders like diabetes and hypertension. Local examination revealed a pedunculated mass measuring 2 cm in diameter protruding from the right side of the labia minora. There was no discharge and no other abnormality was visualised. The regional lymph nodes were not enlarged. Systemic examination revealed no abnormality. Routine blood tests, including VDRL and urinalysis were within normal limits. The lesion was excised with a provisional diagnosis of condyloma acuminatum and sent for histopathology. Light microscopic examination revealed a normal vaginal epithelium. The lamina propria contained multiple cysts of varying sizes (fig 1). The cysts were lined by a single layer of cuboidal cells. Most of the cysts were empty except for scanty hyaline material in some of the larger ones. In between the cysts were lymphohistiocytic infiltrates. Few scattered plasma cells were seen but there were no granulomas or giant cells.

Comment

Vaginitis emphysematosa is not only a rare condition but it is seldom diagnosed on examination as it lacks specific features to

arouse clinical suspicion. Hence it has often been the histopathologist or the radiologist¹ who hints at the possibility of vaginitis emphysematosa. In an exhaustive review of the English literature² the salient features brought out include the occurrence of vaginitis emphysematosa in a wide age range after menarche to well beyond menopause, frequent association with pregnancy and at times cardiopulmonary disease, and involvement of the lamina propria of the upper vagina, extending at times to the lower vagina, the cervix, and rarely the vulva. The main interest in vaginitis emphysematosa has been the histopathological presence of empty cavities in the lesions containing gas similar to atmospheric air³ with a high concentration of carbon dioxide.⁴ How exactly these gases are produced is not clear. Some attribute this to associated trichomonal or *Gardnerella* infection, the cure of which resulted in apparent subsidence of vaginitis emphysematosa.⁵ Immunosuppression as a predisposing factor leading to the development of vaginitis emphysematosa has also been suggested.⁶

Our patient presented with a lesion at the lower end of the vagina that was initially diagnosed as condylomata acuminata. She was not pregnant and had no associated vaginal infection, cardiac disease, or evidence of immunosuppression. Mild inflammatory signs were seen in our patient. Though the term "vaginitis" has been employed it has been observed that inflammation is generally mild or absent.² This may also account for the lack of symptoms in most of these patients. The natural course for vaginitis emphysematosa is to resolve spontaneously and in most patients this has been an accidental finding. On those occasions when the mass makes the patients seek advice simple excision may done as in the present case. Apart from solid tumours like condylomata acuminata, other benign cystic lesions of the vagina like inclusion cyst, Gartner duct cysts, and endometriosis should be considered in the differential diagnosis.

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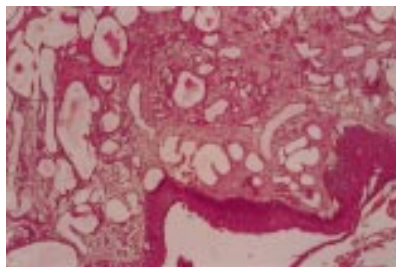


Figure 1 Photomicrograph showing multiple cysts (haematoxylin and eosin stain; original magnification $\times 40$).

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Management of screened chlamydia positive women

Evidence based and minimally harmful management of screened positive people is an essential component of any screening programme.

In the pilot chlamydia programme the protocol for those who screened positive included testing for other genital tract infections.^{1,2} This policy is not evidence based and requires evaluation before roll out of the screening programme nationally.

During the 12 month period September 1999 to August 2000 in Wirral and Portsmouth women throughout the communities up to the age of 25 years were offered a urine LCR test, in general practices, family planning clinics, gynaecology, antenatal, and termination of pregnancy services. Departments of genitourinary medicine (GUM) also offered the test though clearly these were usually for diagnosis rather than true screening.

Results were sent to everyone tested, as in other screening programmes, and an overall positivity of some 10% was found.

Both pilot sites had a central office, which was the initial point of contact for all testing positive. This avoids disparate management by different health professionals and services and had the added benefit of removing concerns raised about time required in each service for managing results, treating, counselling, and partner notification. As our previous experience showed that many people delayed or did not attend a department of GUM when referred,^{3,4} two experienced health advisers were appointed on Wirral and based in the pilot office. These community health advisers had overall responsibility for ensuring and documenting that correct management occurred. People testing positive and reporting symptoms or risk factors were strongly advised to attend the department of GUM and were given a referral letter. However, those who were asymptomatic and who indicated that they did not wish to go were treated according to patient group directions with doxycycline, azithromycin, or erythromycin as appropriate. In these cases the health advisers undertook partner notification and sometimes their treatment. The pilot coordinator (JJH) undertook overall clinical responsibility and saw patients as needed.

During the 12 months of the pilot programme 112 women tested chlamydia positive by the "screening" test in GUM and most returned there for management. Sexually